Volume 4, Issue 3

September 2004

COMPREHENSIVE MEDICAL & DENTAL PROGRAM

DEPARTMENT OF ECONOMIC SECURITY, COMPREHENSIVE MEDICAL AND DENTAL PROGRAM

PROVIDER REVIEW

CMDP's Website www.azdes.gov/dcyf/cmdpe

CMDP Provider Manual and the Provider Review Newsletter are now available on the website.

Upcoming additions are:

- Provider Directory
- Provider Specialist Directory
- Provider Dental Matrix (Dental Fee Schedule)
- Link to AHCCCS Fee Schedule

Provider Terminated for Inactivity

CMDP's provider participation in the AHCCCS program may be terminated for many of several reason, including inactivity.

Provider Participation may be terminated if the provider has not submitted a claim to the AHCCCS Administration or one of the AHCCCS-contracted health plans or program contractors within the past 24-months. If AHCCCS has not received a claim or an encounter from a provider for the past 24 months, that provider was terminated effective April 1, 2004.

Completion of a new registration packet will be required to reactivate providers following termination for inactivity. Contact Provider Services to verify you activity with AHCCCS, (602) 351-2245 or (800) 201-1795.

Step Care

CMDP utilizes tax dollars to provide care to children in foster care, so it is imperative that the most cost-effective pharmacological strategies be employed. As a result, CMDP will be implementing Step Care protocols for Zyrtec, Strattera, Singulair and Prevacid. Step Care is a method of ensuring quality of care utilizing the most appropriate first-line drug choices. Initially, Step Care will apply only to new prescriptions. CMDP will not disrupt current prescription refills.

Zyrtec

With the availability of over-the-counter (OTC) non-sedating antihistamines (NSA), Zyrtec will no longer be available as a first line medication choice. Claritin is the first NSA, and Claritin-D is the first NSA combination product to be available as an OTC. Although differences in sedative effects exist among the NSAs, no difference in efficacy has been demonstrated. As a result, Claritin and Claritin-D, or the generic OTC equivalents are preferred to Zyrtec as the medication of choice.

Some patients may have a documented failure, hypersensitivity, or adverse event to Claritin or Claritin-D and some individuals must take NSA medications chronically for idiopathic urticaria or asthma. These patients can receive approval for a prescription NSA or NSA combination product through the prior authorization process.

Strattera

The majority of medications used in the treatment of ADHD are classified as central nervous stimulants. Strattera, a non-stimulant, has demonstrated equal efficacy to stimulant medication for treatment of ADHD in clinical trials. Well-controlled clinical trials to determine Strattera's place in the management of ADHD are currently being conducted. Until these trials are concluded Strattera is not considered an appropriate first-line medication choice for the treatment of ADD/ADHD.

Continued on page 2…….

Step Care ..... Continued from page 1

Step Care promotes the use of traditional, less expensive ADHD therapy (stimulants) before Strattera is approved. Authorization for Strattera will be considered if:

- o The patient has a failure or intolerance to stimulant therapy
- o The patient has contraindications to stimulant therapy
- o There is concern regarding stimulant therapy and/or reasons for suspecting abuse of a stimulant.

Singulair

The FDA has recently approved Singulair, a Leukotriene Antagonist, for the treatment of allergic rhinitis**.** Singulair is the only agent of this class, to date, to receive an indication for the treatment of allergic rhinitis. The effectiveness of Singulair has not been demonstrated as superior to antihistamines or other medications indicated for allergic rhinitis in clinical studies. Step Care is designed to promote the use of antihistamines, or other medications indicated for allergic rhinitis, as first-line treatment before Singulair is used, as well as to prevent the utilization of Accolate and Zyflo for the treatment of allergic rhinitis.

As with many medication management programs, exceptions exist for which certain patients will be approved for the leukotriene, Singulair. Singulair will be considered in the treatment of allergic rhinitis in the following situation:

- o The patient has a documented failure and/or intolerance to medication(s) FDA-approved for the treatment of allergic rhinitis.
- o These medications include oral antihistamines as well as inhaled corticosteroids and mast cell stabilizers.

Prevacid

The efficacy of proton-pump inhibitors (PPIs) for the treatment of dyspepsia is controversial**.** Intermittent antacids or histamine (H2) antagonists often may successfully manage patients without the use of prescription PPIs.

Step Care will help ensure that patients who may be adequately self-managed with Prilosec OTC (such as those diagnosed with frequent heartburn) have tried and failed Prilosec OTC before using a prescription PPI. When a prescription PPI is appropriate, CMDP will request that you prescribe a generic such as Omeprazole. This will reduce prescription costs associated with use of PPIs and increase movement to Prilosec OTC and generics.

EPSDT UPDATE

When billing for a visit under an EPSDT code you must accompany your billing with an EPSDT form. When providing services for a well woman check and billing it under an EPSDT code you must send in an EPSDT form attached to the claim.

EPSDT forms can be requested from either CMDP or you may go on-line to the AHCCCS Website, www.ahcccs.state.az.us, to print the most recently revised form. Also, when giving immunizations, please record them on the EPSDT form. CMDP is checking to make sure that all immunizations given are logged into the ASIIS system. It is a mandated state law that all immunizations be entered into ASIIS so please don't forget to do so. Developmental and Behavioral Health Screenings are to be recorded on the EPSDT form too.

CMDP is monitoring these activities and will inform your office when this is not being done.

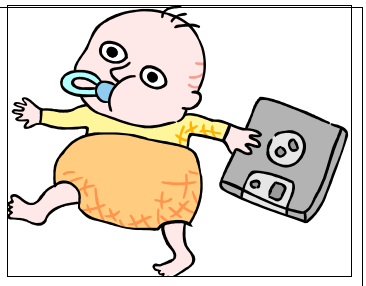
Use of DDAVP in Children with Nocturnal Enuresis

Nocturnal enuresis affects approximately 5 to 7 million children in the United States, making it the most common pediatric urologic complaint encountered by primary care physicians. The most recent edition of the *DSM-IV* defines clinical enuresis as the "repeated voiding of urine during the day or at night into bed or clothes". The frequency criteria are "at least twice per week for at least three months" or the wetting must "cause clinically significant distress or impairment" in social, academic, or other areas of functioning. **The criteria of "clinically significant distress or impairment" is much more subjective.** It seems to have been added to allow clinicians to make the diagnosis in children who do not meet the frequency criteria, but for whom the enuretic events are causing significant emotional distress. Appropriate intervention is justified for the affected child because of the potential consequences of family stress, social withdrawal, and poor self-esteem. The development of bladder control is a multidimensional process that requires sensory awareness of bladder fullness by the child, capacity for storage of urine, voluntary control of the bladder sphincter, psychological desire for control, and a positive training experience. Multiple treatment modalities may be employed to achieve a balanced program with the goals of a significant improvement in the number of wet episodes and cure.

Behavior Modification

Motivational therapy promotes behavior modification by making the child responsible for his or her enuresis and crediting for successful dry nights. Although it is difficult to assess the success of motivational therapy, it has been estimated to be as high as 25%. **Marked improvement as defined by a decrease in enuretic events by 80% or more, however, has been reported in more than 70% of patients.**

Behavioral treatment in the form of bell-and-pad method (arousal systems) of conditioning is usually considered to be the first line of intervention. The general accepted success rate is 75%. Another variation on the original method has been to simply replace the bell-and-pad with an alarm clock that is set to ring at a time when bladder capacity might be expected to reach maximum capacity, or after 2 to 3 hours of sleep. Bladder alarms, depending on the model, cost between $30 and $60. Randomized, controlled trials and clinical studies have shown the alarm system to be effective, and several studies have shown it to be the most effective means of eliminating bed-wetting. **Several studies comparing alarm systems with medical therapy have been performed and the conditioning therapy is reported to be the more effective.**



Drug Therapy – DDAVP (Desmopressin)

The FDA approved the antidiuretic hormone desmopressin acetate for the treatment of nocturnal enuresis in 1990. Success with DDAVP is predicated on a child having achieved normal functional bladder capacity. Therefore, do not employ DDAVP in practice until a child has increased functional bladder capacity and has achieved a healthy pattern of fluid intake. Recommendations suggest prescribing DDAVP to patients for 3 months at full dosage and then employing a gradual taper. Tapering involves titrating the dosage of DDAVP until wetting ceases and maintaining this dosage for 4 to 6 weeks. At this point, the strategy calls for decreasing the dosage by 10 mug every dry 4-week period. If a child relapses, he or she receives an additional 3 months of full-dosage treatment. **Relapse rates on discontinuation of the medication are high.** Studies have shown long-term follow-up indicated that only 5.7% remained dry after cessation of treatment, **confirming the accepted observation that wetting resumes when the medication is stopped.** This medication is probably best reserved for special occasions of sleep-overs with friends, camp, etc. **It is not appropriate to use this medication long-term in a child, in the absence of behavioral interventions.**

The nocturnal wetting episode occurs when the child does not awaken during sleep at a time when urine volume exceeds functional bladder capacity, due either to excess urine production, small bladder capacity, or both. This perspective requires the practitioner to take a careful history for polyuria, sleep dysfunction, and daytime bladder symptoms to devise the best treatment for each child. Although a spontaneous cure rate of 15% per year can be expected, intervention may benefit some children through earlier attained dryness and improved self-esteem. **Behavior therapies, including alarm systems, have the best long-term results, but they require strong family commitment and do not offer immediate results. Medication has a better short-term cure rate than motivational/ behavioral therapy, but relapse rates are high when drugs are discontinued**. Studies clearly show behavior modification is effective and needs to occur at certain intervals with a trial of medication on and off. The ultimate goal is for the child to maintain nighttime dryness or to self-awaken to void at night.

REFERENCES

Lawless M, McElderry D. Nocturnal Enuresis: Current Concepts. *Pediatrics in Review* 2001; 22(12): 399-407

Jalkut M, Lerman S, Churchill B. Enuresis. *Pediatric Clinics of North America* 2001; 48(6)

Mikkelsen E. Enuresis and Encopresis: Ten Years of Progress. *Journal of the American Academy of Child and Adolescent Psychiatry* 2001; 40(10)

Mental Health and Children in Foster Care

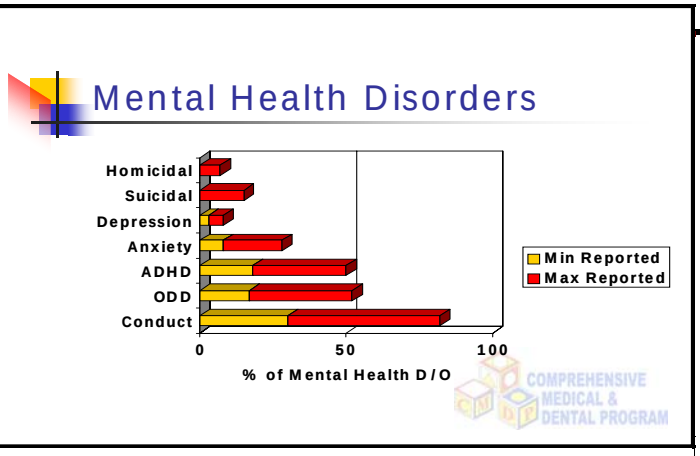
Mental health issues are the most common health problem reported for children in foster care, 85% of children in foster care experience mental health issues and 70% of the children exhibit moderate to severe mental health disorders. The most common mental health issue reported is conduct disorder, however suicidal and homicidal ideation, depression, anxiety disorder, attention deficit hyperactivity disorder and oppositional defiant disorder occur regularly.

Untreated or inadequately treated mental health disorders lead to multiple and unsuccessful placements. This requires more primary care providers to interface with the children and the need for more intensive and expensive treatments. We need to anticipate that our foster children are almost certainly going to have mental health disorders and the need for mental health services. This necessitates referrals to the Regional Behavioral Health Authorities (RBHA), such as Value Options, CPSA, PBGSA, EXCEL, and NARBHA at the time of **entry into foster care.**

Adaptation to foster care is obviously individual and varies with age, placement and personal history. Several themes are common.

- An initial "honeymoon period" where initial adaptation to foster care appears to go well.
- After approximately three months, it is common for the child to demonstrate limit-testing and acting-out behaviors. The child may be withdrawn, depressed, angry, or aggressive.

Severe attachment disorders are less common. Children demonstrating a great difficulty developing relationships



may remain emotionally detached. They may exhibit behaviors around food, such as hoarding, polyphagia, polydipsia and rumination. In addition, repetitive behaviors and self-stimulatory behaviors may be manifested.

Obviously there is a great need for mental health professionals to interrupt these dysfunctional behaviors. Without mental health interventions, these children and adolescents may continue to display extreme behaviors and a lack of emotional reciprocity towards foster parents. This child may experience a succession of foster homes because of "unsuccessful placements". We want to assure a **successful first placement**, therefore we need to refer or **treat mental health disorders early and aggressively!** We need to **anticipate the need for referrals** to the Regional Behavioral Authorities and not wait for the manifestations of psychological, psychiatric or behavioral problems.

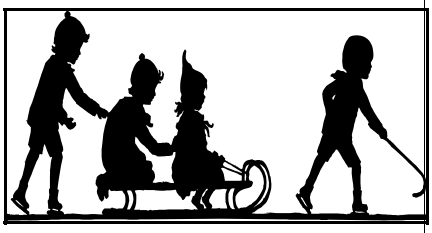
For additional information on mental health and children in foster care, contact Medical or Provider Services at CMDP, (602) 351-2245 or (800) 201-1795.

SYNAGIS

Respiratory syncytial virus (RSV) is the most common cause of bronchiolitis and pneumonia in pediatric patients less than 1 year of age. Factors that increase the risk for developing RSV complications may include chronic lung disease, congenital heart disease, history of apnea or respiratory arrest, immunocompromised patients, pulmonary consolidation on chest radiography, premature infants and certain environmental factors. RSV season typically runs from November through April but may start earlier or later depending on the severity of the virus. Palivizumab (Synagis) has been shown to decrease the risk of severe RSV disease in high-risk infants and children. Synagis is usually started one (1) month prior to the beginning of the RSV season and continued monthly through the remainder of the season. Please, remember Synagis **does require a prior authorization** from CMDP. Once approved, the medication will be sent directly to your office or facility of your choice. **The medication must come from our Pharmacy Benefits Manager; please do not use your stock on hand.** At the beginning of the new season, please contact our Medical Services Unit, at (602) 351-2245 or (800) 201-1795, for any additional information or changes to the current process.

SSRIs and Suicidal Behavior in Youth

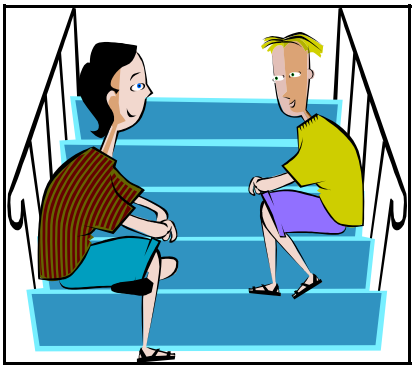
There has been a great deal of recent media attention about the potential correlation between the use of antidepressants known as Selective Seratonin Reuptake Inhibitors (SSRIs) and the risk of suicide in the pediatric and adolescent population. In March 04, the Food and Drug Administration issued a Public Health Advisory for medical professionals to more closely monitor for signs of suicidal ideation in individuals who have recently started taking antidepressant medications in the SSRI category or who have had a recent change in dosage of these. Antidepressant medications involved in this warning include: Prozac (Fluoxetine), Zoloft, Paxil, Luvox, Celexa, Lexapro, Wellbutrin, Effexor, Serzone and Remeron.



The American College of Neuropsychopharmacology published in their Preliminary Report of the Task Force on SSRIs and Suicidal Behavior in Youth (*Psychiatry* Jul 04), their summary of findings as follows: **The Task Force, after reviewing the evidence as a whole, concluded that taking SSRIs or other new generation antidepressant drugs do not increase the risk of suicidal thinking or suicide attempts and that the benefits of SSRIs for treating depression in youth outweigh the risks.**

The Task Force recommended continued use of SSRIs and other new generation antidepressants as an effective and readily available treatment against depression in youth. It also urges clinicians to ask depressed patients about suicide, suicidal thinking and plans for suicide. Regardless of whether an individual is on antidepressants or not, the following suggests an increased risk of suicide and should be carefully assessed in all depressed individuals:

Individuals who are at the highest risk for suicide are those who have made prior suicide attempts and are currently abusing substances.



Other warning signs and factors related to potential suicide include:

- Previous suicide attempts
- Abuse of drugs and/or alcohol
- Suicidal or self-harming thoughts, plans, behaviors and intentions
- Lethality of methods considered
- Feelings of hopelessness, guilt, shame or worthlessness
- Impulsiveness, panic, or anxiety
- No reason for living or lack of future plans
- Serious and chronic medical illness, including chronic pain
- Other signs and symptoms of depression
    - Changes in eating habits
    - Sleeping problems
    - Difficulty concentrating
    - Lack of energy, fatigue, boredom or not caring
- Family history of suicide
- Social problems: Loss of significant relationships, serious financial or legal difficulties, family problems, domestic violence, physical or sexual abuse or neglect, loss of employment, loss of housing, lack of personal supports
- School failure or other problems in school, being "bullied" by other children
- Poor control of emotions: anger, irritability, agitation, rebelliousness, or impulsiveness
- Getting rid of valued personal possessions
- Recent personality changes, poor coping under stress, or poor self-esteem
- Changes in personal hygiene
- Mental confusion or impaired thinking

Populations at higher risk of Suicide:

- Individuals with a history of: Depression, Major Depression, Bipolar Disorder (Mania), Schizophrenia, Substance Use Disorders, Anxiety Disorders or Borderline Personality Disorder
    - *Please remember that a major depressive episode may be the initial presentation of bipolar disorder and that treatment with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar disorder..*
- Adolescents and young adults
- Males
- White/Caucasians
- Gay, lesbian, bisexual or transgender orientation
- Native Americans

CMDP Contacts:
(602) 351-2245 (800) 201-1795

MEMBER SERVICES:

Linda Moore.....ext 7076
Mirtha Moreno.....ext 7080
Maria Villanueva.....ext 7083

We are available to verify a member's eligibility. Please call with their name, date of birth, date of service and ID number.

PROVIDER SERVICES:

Cathy Nunez.....ext 7042
Robert Casillas.....ext 7112
Cori Rackley.....ext 7110

For all your concerns, Provider Services will assist your needs or direct you to the appropriate department.

CLAIMS:

For verification of claim status, please ask the operator for a claims representative.

MEDICAL SERVICES:

Susan Stephens, M.D., Medical Director.....ext 7065
Mary Ferrero, R.N., Medical Services Manager.....ext 7070
Hospitalizations.....ext 7116
EPSDT.....ext 7063
Prior Authorizations .....ext 7067
Behavioral Health.....ext 7009 / 7060
Social Services, ER, Dental.....ext 7073

Please contact Medical Services with any questions regarding the medical needs of our members.

"Web Corner"

The following is a list of web sites we recommend to assist your office. If there are any you wish to add and share with other providers please contact Provider Services.

CMDP's Website: www.de.state.az.us/links/foster/cmdpe/index.html
UPDATED CAP FEE SCHEDULE, AHCCCS Provider Manual , EPSDT forms and more available at: www.ahcccs.state.az.us
CHILDREN'S REHABILITATIVE SERVICES (CRS), information and referral forms: www.hs.state.az.us/phs/ocshcn/crs/index.htm
Need any GROWTH-CHARTS? Download them from the CDC: www.cdc.gov/growthcharts/
VACCINES FOR CHILDREN (VFC) Program: www.cdc.gov/nip/vfc/Provider/ProvidersHomePage.htm
Every Child by Two Immunizations: www.ecbt.org
ASIIS and TAPI: www.whyimmunize.org/us.htm
Health Data Management: www.healthdatamanagement.com
American Academy of Pediatrics: www.aap.org
National Center for Children in Poverty: www.nccp.org

Equal Opportunity Employer/Program
This document available in alternative formats by contacting Provider Services.

Cultural Competency

In a society as culturally diverse as Arizona, Health Care providers need the ability to communicate with diverse members and their foster caregivers. Providers should also have the knowledge to understand the culturally influenced health behaviors CMDP members may have.

Benefits of Cultural Competency

Some benefits for CMDP Providers to be culturally competent are:

- Gain sensitivity to patient needs; reduce prejudice and bias
- Improve the quality of patient care and outcomes
- Improve patient and foster caregivers satisfaction
- Reduce non-compliance of patients and foster caregivers
- Develop more appropriate plans of care
- Work better with diverse member populations
- Have a better understanding of other cultures' approach to health care for children
- Reduce patient complaints

There is a natural tendency for people to be culturally bound, to assume their values, customs, attitudes and behaviors are always appropriate and right. Cultural Competence requires us to respond to diverse populations, without allowing our own cultural values, beliefs and behaviors to interfere with providing quality customer service to all. It is important to be aware of cultural differences and truly aware of individuals and their needs.

The Internet has an abundance of information on Cultural Competency. A few of the Websites are listed below:

- www.baylor.edu/charles_kemp/hispanic_health Great site for information on Hispanic and other cultures.
- www.nul.org National Urban League (212) 310-9000
- www.greaterphxurbanleague.org Greater Phoenix Urban League
- www.raceandhealth.hhs.gov U.S. Department of Health and Human Services: The Initiative to Eliminate Racial and Disparities in Health. This site is being revised.
- www.aapcho.org Association of Asian Pacific Community health Organizations (AAPCHO) (510-272-9536.
- www.cossmho.org National Coalition of Hispanic Health and Human Services Organizations (202) 387-5000.